STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445319	A. BUILDING _____ B. WING _____	C 11/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	32 MEMORIAL DRIVE WINCHESTER, TN 37398

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F 000	INITIAL COMMENTS Complaint investigation #39879 was completed at Willows at Winchester Health and Rehabilitation Center on 10/31/16-11/1/16. Deficiencies were cited under 42 CFR Part 483 Requirements for Long Term Care Facilities.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Willows of Winchester does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to follow their policy for controlled substances which allowed for misappropriation of narcotics for 1 resident (#1) of 3 residents reviewed for misappropriation. The findings included: Review of facility policy, Controlled Substances, revised 12/12 revealed, "...The facility shall comply with all laws, regulations...required to handling, storage...of Schedule II and other controlled substances...Controlled substances must be stored in the medication cart under double lock...except when it is accessed to obtain medications for residents...Nursing staff must count controlled medications at the end of each	F 224	**F 224** **1.How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **The facility was charged for Resident #1 Ativan on 11/04/16. Resident #1 expired on 10/18/16.** **2. How the facility will identify other residents having potential to be affected by the same deficient practice.**	**11/14/16**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 11/14/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 1 shift..." Review of facility policy, Storage of Medications, revised 4/07 revealed, "...The facility shall store all drugs...in a safe, secure, manner...Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station...Narcotics requiring refrigeration should be secured to the inside of the refrigerator in a locked box..." Medical record review revealed Resident #1 was admitted to the facility on 9/6/13 and readmitted on 11/26/14 with diagnoses including Alzheimer's, Psychotic Disorder with Delusions, Depression, Anxiety, Cerebral Atherosclerosis, and Congested Heart Failure. The resident was placed on hospice on 8/25/16 and expired on 10/18/16. Medical record review of a Physician's order dated 8/27/16 revealed "Lorazepam [also known as Ativan-Benzodiazepine used to treat anxiety] Intensol [solution] 2 mg/ml [milligrams per milliliter] give 0.25 ml sublingual every 6 hours as needed for anxiety." The bottle contained 30 ml of the medication. Medical record review of the October 2016 Medication Administration Record (MAR) and Controlled Substances form revealed the resident was administered Ativan on 10/2/16 at 1:00 PM and 10/4/16 at 9:00 PM. The amount left to count was 29.5 ml. Review of a facility investigation with an occurrence date of 10/8/16 at 7:54 PM revealed during change of shift narcotic count of medication cart C, the oncoming Licensed Practical Nurse (LPN) #1 and off going LPN #2	F 224	**All residents have potential to be affected. A narcotic count on all medication carts and narcotics stored in the medication room refrigerator was conducted during facility investigation on 10/08/16 by the Director of Nursing with no discrepancies found. All medications were also found to be stored correctly at that time.** **3. What measure will be put in place or systemic changes made to ensure that deficient practice will not recur.** **Licensed nursing staff were in-serviced by the Director of Nursing and Staff Development Coordinator on the Abuse Policy when facility investigation was conducted. This was initiated on 10/9/16 and completed on 11/11/16.** **The facility's Medication Storage and Controlled Substances policy in-servicing was initiated on 10/9/16 and completed by 11/11/16 to ensure proper storage of medications, narcotic counts, and immediately reporting any discrepancies found to the Director of Nursing. The Director of Nursing will audit the narcotic counts and reconciliations 3/x week x 4 weeks,**	

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F 224	Continued From page 2 discovered Resident #1's bottle of Ativan was unable to be located. Telephone interview with LPN #1 on 11/1/16 at 9:35 AM revealed the LPN stated, "I was counting with [LPN #2] and was told [Resident #1's] Ativan had been moved from the cart to the refrigerator [in the medication room] a few days ago because it had been opened. I went to check the refrigerator and it wasn't there. Continued interview revealed the LPN stated, "A few days later I went to the police station and observed a video the facility had given them. It showed me removing the Ativan from the med [medication] cart on Tuesday [10/4/16] around 8:45 PM or so and going into [Resident #1's] with the bottle of Ativan. I remembered he was so anxious and his head was at the foot of the bed. When I came out of the room I told my tech we needed to move him back to the head of the bed. I put the Ativan back in its box when the tech called me into the room to help reposition the resident. I hadn't locked it back in the med cart, so I took the Ativan in the room with me. I must have laid it down to help move the resident back to the head of the bed because I used 2 hands to do that and forgot to bring it out with me and lock it back up." When asked where she had laid the bottle of Ativan, LPN #1 stated, "I really can't recall, but it must have been close to the resident. Either on the foot of the bed, or the bedside table." The LPN confirmed she was the last nurse to administer the Ativan before it was determined to be missing. Interview with LPN #2 on 11/1/16 at 11:00 AM, in the conference room revealed LPN #3 had counted med cart C on 10/8/16 at 7:00 AM with LPN #3 and she told her the Ativan had been moved to the refrigerator in the med room. LPN	F 224	then weekly x 4 weeks, then monthly x 2 months to ensure compliance with narcotic counts, immediate reporting of discrepancies to the Director of Nursing, and to ensure proper storage for medications requiring refrigeration. All new hire licensed nurses will be in-serviced during their orientation period by the Director of Nursing or Staff Development Coordinator. **4. How the facility will monitor its corrective actions to ensure the deficient practice will not reoccur.** **The Administrator or Director of Nursing will present results of the Narcotic and Reconciliation audit to the monthly Quality Assurance Performance Improvement Committee (members include Committee Chairperson – Administrator; Director of Nursing Services; Assistant Director of Nursing Services; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director;**	

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F 224	Continued From page 3 #2 stated, "I failed to verify it was there." Continued interview revealed on 10/8/16 at 7:00 PM during the countin of the narcotics on the med cart with LPN #1 it was discovered the bottle of Ativan was missing. Telephone interview with LPN #3 on 11/1/16 at 1:15 PM revealed she was told by LPN #4 on 10/5/16 at 7:00 PM during shift change and count of med cart C the Ativan for the resident was moved to the refrigerator in the med room. The LPN stated, "I did not check the refrigerator to see if it was there." LPN #3 confirmed the last time she saw the bottle of Ativan was on 10/2/16. Telephone interview with LPN #4 on 11/1/16 at 1:30 PM revealed "I was told by [LPN #1] on Wednesday 10/5/16 at 7:00 AM shift change and count of med cart C that the Ativan was moved to the refrigerator." The LPN confirmed she did not go check the refrigerator to verify the Ativan was there and stated, "I thought it was moved on Monday or Tuesday because [LPN #5] told us it's supposed to be stored in the refrigerator. I opened it on Sunday (10/2) and gave some to the resident and put it back in the cart. I counted with [LPN #6] around 1 or 2 PM and the count was correct, and the Ativan was there." Interview with the Director of Nursing (DON) on 11/1/16 at 3:00 PM in the conference room confirmed the facility failed to follow their policy and perform complete narcotic (controlled substance) counts and reconciliation from 10/5/16 at 7:00 AM through 10/8/16 at 7:00 AM., resulting in misappropriation of 29.5 mls of Ativan for Resident #1.	F 224	and Medical Records Director) x 4 months for further follow up and or recommendations as needed. **Date of Compliance: 11/14/16**	
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431	**F 431**	

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F 431 SS=D	Continued From page 4 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record	F 431	**1. How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **Resident #1 expired on 10/18/16.** **2. How the facility will identify other residents having potential to be affected by the same deficient practice.** **All residents have potential to be affected. A narcotic count on all medication carts and narcotics stored in the medication room refrigerator was conducted during facility investigation on 10/08/16 by the Director of Nursing with no discrepancies found. All medications were also found to be stored correctly at that time.** **3. What measure will be put in place or systemic changes made to ensure that deficient practice will not recur.** **The facility's Medication Storage and Controlled Substances policy**	11/14/16

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F 431	Continued From page 5 review, observation, and interview, the facility failed to properly store liquid Ativan (Benzodiazepine medication used to treat anxiety) in the medication refrigerator according to manufacturer's recommendations and as labled by the pharmacy for 1 resident (#1) of 3 residents reviewed. The findings included: Review of facility policy, Storage of Medications, revised 4/07 revealed, "...The facility shall store all drugs...in a safe, secure, manner...Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station...Narcotics [controlled substances] requiring refrigeration should be secured to the inside of the refrigerator in a locked box..." Medical record review revealed Resident #1 was admitted to the facility on 9/6/13 and readmitted on 11/26/14 with diagnoses including, Alzheimer's, Psychotic Disorder with Delusions, Depression, Anxiety, Cerebral Atherosclerosis, and Congested Heart Failure. The resident was placed on hospice on 8/25/16 and expired on 10/18/16. Medical record review of a Physicians order dated 8/27/16 revealed "Lorazepam [also known as Ativan-Benzodiazepine used to treat anxiety] Intensol [solution] 2 mg/ml [milligrams per milliliter] give 0.25 ml sublingual every 6 hours as needed for anxiety." The bottle contained 30 ml of the medication. Observation of the medication room refrigerator on 10/31/16 at 9:30 AM, with the Director of	F 431	in-servicing was initiated on 10/9/16 and will be completed by 11/14/16 to ensure proper storage of medications, narcotic counts, and immediately reporting any discrepancies found. The Director of Nursing will audit the narcotic counts and reconciliations 3/x week x 4 weeks, then weekly x 4 weeks, then monthly for 2 months to ensure compliance with narcotic counts, immediate reporting of discrepancies to the Director of Nursing, and to ensure proper storage for medications requiring refrigeration. All new hire licensed nurses will be in-serviced during their orientation period by the Director of Nursing or Staff Development Coordinator. **4.How the facility will monitor its corrective actions to ensure the deficient practice will not reoccur.** **The Administrator or Director of Nursing will present results of the Narcotic and Reconciliation audit to the monthly Quality Assurance Performance Improvement Committee (members include Committee Chairperson – Administrator; Director of Nursing Services; Assistant Director of Nursing**	

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F 431	Continued From page 6 Nursing (DON) revealed a locked refrigerator requiring a key to open and a clear plastic locked narcotic (controlled substance) box inside the refrigerator requiring a separate key. No narcotics were present at this time inside the narcotic box. Observation and interview with the Pharmacy Consultant and the DON on 11/1/16 at 9:00 AM, in the medication room revealed the disposal container for wasted medications was opened. Continued observation revealed a 30 ml bottle of Ativan inside the box for Resident #1. The box had a label added by the pharmacy that read "Refrigerate" in light blue letters located at the bottom of the box. Continued observation revealed instructions to store at 36-46 degrees Fahrenheit were included on the outside of the box of Ativan. The Pharmacy Consultant and DON confirmed the Ativan was to be stored in the medication refrigerator when it was received at the facility. Telephone interview with Licensed Practical Nurse (LPN) #1 on 11/1/16 at 9:35 AM confirmed the Ativan for Resident #1 had been stored in the medication cart. Interview with LPN #2 on 11/1/16 at 11:00 AM, in the conference room revealed, "After a dose of Ativan was given, it had been kept on the cart, not in the refrigerator." Telephone interview with LPN #3 revealed, "The box (of Ativan) had a label on it to refrigerate." When asked why it was stored in the medication cart, the LPN stated, "I'm not sure. They told us in an in-service to refrigerate it when it comes from the pharmacy."	F 431	Services; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director) x 4 months for further follow up and or recommendations as needed. **Date of Compliance: 11/14/16**	

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F 431	Continued From page 7 Telephone interview with LPN #4 on 11/1/16 at 1:30 PM revealed, "I opened it [Ativan] on Sunday [10/2], gave it, and put it back in the cart." When asked if the Ativan was labeled to refrigerate the LPN stated, "I honestly didn't look." Interview with the DON on 11/1/16 at 3:00 PM, in the conference room confirmed the facility failed to store Ativan in the medication refrigerator as labeled for Resident #1.	F 431		